ONTARIO PRIMARY CARE COUNCIL ROLE OF PRIMARY CARE IN CARE COORDINATION
Position on Principles of Care Coordination Leading to Seamless Transitions for Patients and Families

Background
The Ministry of Health and Long-Term Care is transforming how care is delivered to Ontarians. The Ontario Government’s Excellent Care for All Act and the Action Plan for Health Care aim to enable a health system that better responds to patient needs and delivers high quality care that is both accessible and affordable. Central to achieving elements of the Action Plan for Health Care is robust and well-coordinated primary care. Primary care is an anchor for patients and families and is well positioned to support better care coordination in primary care, including system navigation across the health system and social services.

The Ontario Primary Care Council affirms effective care coordination as a dimension of quality primary care that is patient-centered and leads to effective and more seamless transitions in care between settings and among providers. Care coordination would ensure continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility or their family practice, among others. The Council has identified coordination of care as an area of shared focus because of its potential for significant positive impact on patient outcomes, health care delivery, and enabling Ontario’s Action Plan for Health.

Position Statement
The Ontario Primary Care Council (OPCC) asserts the role of primary care providers to lead care coordination and access to appropriate programs or services. Primary care providers will work to ensure access to interprofessional care for patients and will identify a point of contact, to help patients and families navigate and access programs and services.

Effective care coordination will lead to more seamless transitions for patients and families, reduce duplication, increase quality of care, facilitate access, and contribute to better value by reducing costs. The OPCC believes care coordination requires dedicated funding and leadership support through training and education.

Definition of Care Coordination
To facilitate the appropriate delivery of health services, care coordination is the deliberate organization of care, services and programs that involves two participants (including the person receiving services and their family). Organizing care involves the marshaling of personnel and other resources needed to carry out all require activities, and is often managed by the exchange of effective and timely information among participants responsible for different aspects of services the person requires.¹

¹ Definition is an adaptation of the RNAO definition from “Enhancing Community Care for Ontarians 1.0” (www.rnao.ca/ecco) and the Agency for Healthcare Research and Quality (US) working definition of care coordination from “Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)” 2007 Jun.
Principles of Care Coordination and Desired Outcomes
The Council’s focus is guided by five principles of person-centred care coordination. These principles are shared by member organizations of the Council, and generally guide many primary care transformation initiatives. Desired outcomes are identified against each principle.

<table>
<thead>
<tr>
<th>Principles of Care Coordination</th>
<th>Desired Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care coordination is a core function of primary care and a hallmark of a high-performing primary care system.</td>
<td>Care coordination is provided through the patient’s primary care organization throughout their life span.</td>
</tr>
<tr>
<td>2. Care coordination includes communication and planning with the patient and family.</td>
<td>Patients are at the centre of their plan of care. Their perspectives are fully integrated in the formulation of this plan.</td>
</tr>
<tr>
<td>3. Care coordination requires a population needs based approach to planning.</td>
<td>A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care and care coordination.</td>
</tr>
<tr>
<td>4. Care coordination will emphasize the timely and continuous delivery of high-quality, person-centred, equitable, timely and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.</td>
<td>There is evidence that patients receive high quality care that reflects services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.</td>
</tr>
<tr>
<td>5. Care coordination focuses on the provision of comprehensive services across the health and social services continuum as needed.</td>
<td>There is evidence that patients experience timely access to services and seamless transitions in care.</td>
</tr>
<tr>
<td>6. Care coordination is predicated on collaborative interprofessional teams working to full scope of practice.</td>
<td>There is evidence that patient care is optimized when all health-care professionals are working collaboratively each at their full scope of practice.</td>
</tr>
</tbody>
</table>

Ontario Primary Care Council members:
Association of Family Health Teams of Ontario
Association of Ontario Health Centres
Nurse Practitioners’ Association of Ontario
Ontario Medical Association
Ontario Pharmacists Association
Registered Nurses’ Association of Ontario
The Ontario College of Family Physicians